Seitlin & Seitlin DDS, PLLC
1014 East Blvd
Charlotte, NC 28203
Phone (704) 375-2030
Fax (704) 371-4480
www.seitlindental.com

New Patient Packet

Dear New Patient,

We want to thank you for choosing our practice for your dental care. We are thrilled you chose us. Attached is the office paperwork that needs to be completed prior to your appointment. Please complete all forms and return within 2 days of your scheduled appointment time. If you cannot complete the paperwork prior, please arrive 30 minutes early to do so.

Current X-rays
We request that you contact your previous dentist or insurance company regarding the dates of your most recent x-rays. This will save time during your first appointment.

Please find the most recent dates for:

- Full Mouth Series of Films_____
- Panoramic Film_____
- Bitewing Films_____

Insurance Information
Your Social Security Number must be provided on your registration form in order for us to file insurance claims for you and to carry a balance with our practice. Also, if your insurance is NOT in your name, please provide the name, address, Social Security Number, and the date of birth of the policy holder as well as your own information on the registration form.

Pre-medication
If you need to take pre-medication prior to a dental appointment, please bring your prescription with you at your first appointment so we can prescribe it for you in the future.

Our HIPPA Privacy Policy is available upon request.

Please complete this packet and email to frontdesk@seitlindental.com.
You can also fax it to us or drop it off at our office address.

We look forward to meeting you soon!

CONFIDENTIAL

We are happy to welcome you to our office!
Please completely fill out this form and if you have any questions, we will be glad to help you!

Patient Information

Date_____

Patient's last name_____ First name_____ Middle initial_____

Prefers to be called_____ Date of Birth _____ Sex O Male O Female

Social Security# _____ School_____

Email address(es) _____

Home address _____ City, State, Zip code_____

Home phone ( ) _____ Cell phone ( ) _____

Parent / Guardian (if patient is under 18)

Custodial parent(s) name(s)_____

Patient lives with (check all that apply) O Mother O Father O Stepmother O Stepfather O Grandparent(s)

O Other_____

Primary Guardian Full Name_____Date of Birth_____

Occupation_____ Email address_____

Address (if different)_____

Home Ph. ( )_____ Cell Ph. ( )_____ Work Ph. ( )_____

Secondary Guardian Full Name_____Date of Birth_____

Occupation_____ Email address_____

Address (if different)_____

Home Ph. ( )_____ Cell Ph. ( )_____ Work Ph. ( )_____

Financial Responsibility

Who is financially responsible for this account?_____

Address_____

City _____ State_____ Zip code_____

Home phone ( )_____ Cell phone ( ) _____

Email address(es)_____

Social Security #_____ Employer_____

Who will be responsible for bringing the patient to appointments? _____

Dental / Orthodontic Insurance

Primary policy holder's full name_____ Date of Birth_____

Social Security #_____ Relationship to patient_____

Address and phone (if not listed above)_____

Employer_____ Address_____

Insurance company _____ Group #_____ ID#_____

Does this policy have orthodontic benefits? O Yes O No O Don't Know

Secondary policy holder's full name_____ Date of Birth_____

Social Security #_____ Relationship to patient_____

Address and phone **(if not listed above)**_____

Employer_____ Address_____

Insurance company _____ Group #_____ ID#_____

Does this policy have orthodontic benefits? O Yes O No O Don't Know

Dental Medical History Form (Version 8/2015)

Patient Name: _____ Birth Date: _____

Although we primarily treat the area in and around the mouth, one's mouth is a part of the entire body. Previous health problems and/or medication could have an important interrelationship with the dentistry the patient will receive. Please answer each of the following questions as completely as possible. Thank you!

Is the patient under a physician's care now?	O Yes O No	If yes _____
Has the patient ever been hospitalized or had a major operation?	O Yes O No	If yes _____
Has the patient had a serious head or neck injury?	O Yes O No	If yes _____
Is the patient taking medications, pills, or drugs?	O Yes O No	If yes _____
Does the patient take, or have taken, Phen-Fen or Redux?	O Yes O No	If yes _____
Is the patient on a special diet?	O Yes O No	If yes _____
Does the patient use tobacco?	O Yes O No	If yes _____
Please list previous hospitalizations/Surgeries/Serious Illnesses?	O Yes O No	If yes _____

Women: Are You...? O Pregnant/Trying to get pregnant O Nursing O Taking Oral Contraceptives

Is the patient allergic to any of the following?

O Aspirin O Penicillin O Codeine O Acrylic
O Metal O Latex O Local Anesthetics

Other Allergy? O Yes O No If yes _____

Does the patient have or had, any of the following?

ADD/ADHD O Yes O No	Convulsions O Yes O No	Heart Pacemaker O Yes O No	Recent Weight Loss O Yes O No
AIDS/HIV Positive O Yes O No	Cortisone Medicine O Yes O No	Heart Trouble/Disease O Yes O No	Renal Dialysis O Yes O No
Anaphylaxis O Yes O No	Diabetes I O Yes O No	Hemophilia O Yes O No	Rheumatic Fever O Yes O No
Anemia O Yes O No	Diabetes II O Yes O No	Hepatitis A O Yes O No	Rheumatism O Yes O No
Angina O Yes O No	Down Syndrome O Yes O No	Hepatitis B or C O Yes O No	Scarlet Fever O Yes O No
Anxiety' Disorder O Yes O No	Drug Addiction O Yes O No	Herpes O Yes O No	Shingles O Yes O No
Arthritis/Gout O Yes O No	Easily Winded O Yes O No	High Blood Pressure O Yes O No	Sickle Cell Disease O Yes O No
Artificial Heart Valve O Yes O No	Emphysema O Yes O No	High Cholesterol O Yes O No	Sinus Trouble O Yes O No
Artificial Joint O Yes O No	*Epilepsy or Seizures O Yes O No	Hives or Rash O Yes O No	Special Needs/
Asperger's O Yes O No	Excessive Bleeding O Yes O No	Hypoglycemia O Yes O No	Developmental Delay O Yes O No
Asthma O Yes O No	Excessive Thirst O Yes O No	Irregular Heartbeat O Yes O No	Spina Bifida O Yes O No
Autism O Yes O No	Fainting Spells/Dizziness O Yes O No	Kidney Problems O Yes O No	Stomach/Intestinal Disease O Yes O No
Blood Disease O Yes O No	Fetal Alcohol Syndrome O Yes O No	Leukemia O Yes O No	Stroke O Yes O No
Blood Transfusion O Yes O No	Frequent Cough O Yes O No	Liver Disease O Yes O No	Swelling of Limbs O Yes O No
Breathing Problems O Yes O No	Frequent Diarrhea O Yes O No	Low Blood Pressure O Yes O No	Thyroid Disease O Yes O No
Bruise Easily O Yes O No	Frequent Headaches O Yes O No	Lung Disease O Yes O No	Tonsillitis O Yes O No
Cancer O Yes O No	Genital Herpes O Yes O No	Mitral Valve Prolapse O Yes O No	Tuberculosis O Yes O No
Chemotherapy O Yes O No	Glaucoma O Yes O No	Pain in Jaw Joints O Yes O No	Tumors or Growths O Yes O No
Chest Pains O Yes O No	Hay Fever O Yes O No	Parathyroid Disease O Yes O No	Ulcers O Yes O No
Cold Sores/Fever Blisters O Yes O No	Heart Attack/Failure O Yes O No	Psychiatric Care O Yes O No	Venereal Disease O Yes O No
Congenital Heart Disorder O Yes O No	*Heart Murmur O Yes O No	Radiation Treatments O Yes O No	Yellow Jaundice O Yes O No

*If Heart Murmur, does the patient require antibiotics prior to dental treatment? O Yes O No If yes _____

*If Epilepsy or Seizures, date of last seizure? O Yes O No If yes _____

Has the patient ever had any serious illness or condition not listed above? O Yes O No If yes _____

Does the patient have any of the following habits?

O Sucking thumb/finger O Suck/Bite Lip O Chew/Bite nails
O Chew hard objects O Grind Teeth O Clench Jaw

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to the patients' health. It is my responsibility to inform the dental office of any changes in the patients' medical status. I also authorize the dental staff to perform the necessary dental services the patient may need.

X_____ _____
Signature of Patient, Parent or Guardian Date

This form has been reviewed with Patient, Parent or Guardian and conditions accurately notated.

X_____ _____
Signature of Providing Dentist Date

Seitlin & Seitlin, DDS PLLC
Financial Information

Thank you for selecting our office for your dental needs. Our goal is to provide you with prompt, courteous, and quality dental care.

Payment is due at the time services are rendered. Payment options include:

1. **Cash**, money orders, and personal checks are accepted.

2. **Credit Cards** we accept are Visa, Mastercard, Discover, and American Express.

3. **CareCredit** is a third party financing option we offer as a line of credit to cover you and your family members' healthcare needs. Please ask a receptionist to find out more about this choice.

4. **Insurance**

In most instances, we will accept assignment of insurance benefits. We will be happy to process your dental claim as long as you bring your current dental insurance card and provide accurate information for filing. We participate with many dental insurance carriers and there are many different plans with many different options.

Your insurance policy is a contract between you, your employer and the insurance company. We are not a party to that contract. Our relationship is with you, not your insurance company. However, we are happy to file insurance claims as a courtesy to you.

- All charges are your responsibility whether your insurance company pays or not.
- Most insurance plans do not cover all services.
- Some employers and insurance companies select certain services they will not cover.
- Fees for non-covered benefits, along with unpaid deductibles and co-payments are due at the time service is rendered.
- If the insurance company does not pay your balance in full within 30 days, we ask that you contact the carrier to help speed up processing of your claim.
- If the insurance company does not pay in full within 60 days, we require you to pay the balance due. Interest on unpaid balances will accrue at the rate of 18% per year. A $5.00 monthly billing fee will be charged to accounts over 90 days old.
- There is a $30.00 charge for all checks returned from your bank for any reason

Payment Plans

If you are unable to pay in full at the time of service, we may choose to offer you a payment plan. One third of your balance will be due when treatment is started, and the remainder will be due as two consecutive equal monthly payments 30 days and then 60 days later. We require credit card information to be kept on file for automatic withdrawals. **It will be our choice to offer a payment plan to you.**

We reserve the option to apply a charge if you fail to show for an appointment or if you cancel an appointment without 48 hours notice.

If you have any questions regarding our financial policy, please feel free to contact our office at (704) 375-2030.

Patient's Signature:_____

By my signature I indicate that I have read this policy, understand its content and agree to its provisions.

Seitlin & Seitlin, DDS PLLC
Electronic Information Consent

Until I tell you in writing to stop, I authorize Seltiin and Seitlin DDS PLLC to transmit patient information relating to my treatment, health, or payment, by email or other electronic means, with encryption or special security precautions, to me or someone I designate, or to other health care providers, health plans and others involved in my treatment, payment for my treatment, or dental health care operations. The patient information that may be emailed may include my x-rays, relevant health history, diagnosis, treatment, and payment records.

I understand that:

- I do not have to sign this form.
- My treatment, payment, enrollment and eligibility for benefits will not be affected if I refuse to sign this form.
- If I don't sign this form, Seitlin and Seitlin, DDS PLLC may use other ways to send my information, such as US Mail, or may ask me to send my information to third parties myself.
- If I don't sign this form, this can cause a delay in payment and transferring of information between parties.
- There is some risk that emails and other electronic messages may be improperly acquired by hackers or received by unintended recipients. If that happens, the information may be redisclosed and no longer protected by privacy law.
- Seitlin and Seitlin, DDS PLLC does not email such sensitive personal information as Social Security number, credit card number, mental health diagnosis, genetic information, alcohol/substance abuse, or positive HIV status unless the patient insists.

I can notify writing Seitlin and Seitlin, DDS PLLC to stop emailing my patient information at any time, but if I do so, this will not affect emails that have already been sent.

By my signature I indicate that I have read this consent form, understand its content, and agree to its provisions.

Patient Name:_____

Patient Signature:_____

Relationship (if patient is a minor): _____

Date:_____

OFFICE USE ONLY

_____

I attempt to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

Seitlin & Seitlin, DDS PLLC
Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment among the multiple healthcare providers who may be involved in my treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand a *Notice of Privacy Practices* document containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at its current address to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment or payment of health care operations at any time. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name:_____

Patient Signature:_____

Relationship (if patient is a minor): _____

Date:_____

OFFICE USE ONLY

_____

I attempt to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

Seitlin & Seitlin, DDS PLLC
Periodontal Insurance Information

Periodontitis, or “gum disease”, is a major cause of tooth loss. Upon examining your mouth, your doctor and hygienist will determine what kind of dental cleaning is best for you. There are several different kinds of dental cleanings, each with its own insurance ramifications. This sheet will help explain them to you.

Adult Prophylaxis
An adult prophylaxis or “prophy” is the simplest and least invasive type of dental cleaning. This service is normally covered by dental insurance twice a year. This is also considered a routine cleaning and can only be performed on someone who is in good periodontal health. This type of cleaning is not recommended for someone with gingivitis or large amounts of calculus (tartar) buildup. **A prophylaxis is a preventative procedure and insurance companies will usually pay all or most of the cost for this service.**

Full Mouth Debridement
This type of cleaning is usually recommended for someone who has not seen a dentist in over a year, or for someone who needs to improve their oral hygiene. Poor homecare leads to tartar and plaque buildup on your teeth that often require more than just an adult prophylaxis to remove. **Insurance companies typically do not cover 100% of the fee for this service.** With an improvement in oral hygiene and follow-up visits after a full mouth debridement, one could return to an Adult prophylaxis schedule twice a year which is covered by insurance.

Scaling and Root Planning
A patient diagnosed with periodontal disease requires a cleaning known as Scaling and Root Planning or a “deep cleaning”. This is also known as a “deep cleaning”. It usually requires numbing of your gum tissue and takes 2 visits, each lasting about an hour and a half. During this procedure, your hygienist must remove tartar buildup below the gum line and smooth and polish the roots of your teeth so that calculus will not buildup as easily again. The fee higher for this service due to the time requirement and amount of work needed to be done. **Insurance coverage for this procedure varies widely and some companies provide no coverage for it at all.**

Periodontal Maintenance
Patients that have completed scaling and root planing are required to have periodontal maintenance visits. Periodontal maintenance is required following scaling and root planning. This is different than than a regular adult prophylaxis and is done to monster and maintain the deep cleaning performed at scaling and root planning visit. Periodontal maintenance appointments occur in 4 month intervals. After 2 years of maintaining a healthy mouth, one can usually revert to regular 6 month adult prophylaxis appointments. **Insurance companies will typically apply your yearly deductible and pay 50% to 80% coverage 2 to 4 times per year for Periodontal Maintenance.**

If you are uncertain of your insurance benefits regarding periodontal treatment, you can contact your insurance carrier directly. We will also be happy to submit a pre-authorization for approval to determine your benefits.

Patient's Signature:_____

By my signature I indicate that I have read this information, understand its content, and agree to its provisions.

Seitlin & Seitlin, DDS PLLC
COVID-19 (Coronavirus) Pandemic Dental Treatment Consent Form

Patient Name: Date of Birth:

I knowingly and willingly consent to have dental treatment completed during the COVID-19 pandemic.

I understand the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms and still be highly contagious.

There are several modes of transmission of COVID-19 which could be present in a dental office. We are following the ADA and CDC guidelines to minimize the risk of transmission.

Please initial the following sections:

_____I understand that due to the frequency of visits of other dental patients, the characteristics of the virus, and the characteristics of dental procedures, that I have an elevated risk of contracting the virus simply by being in a dental office.

_____I confirm that I am not presenting any of the following symptoms of COVID-19 listed below:

- Fever
- Shortness of Breath
- Dry Cough
- Runny Nose
- Sore Throat

_____The CDC recommends social distancing of at least 6 feet and this is not possible with dentistry.

_____I verify that I have not traveled outside the United States in the past 14 days.

_____I verify that I have not traveled domestically within the United States by commercial airline, bus, or train within the past 14 days.

By my signature I indicate that I have read this consent form, understand its content, and agree to its provisions.

Signature:

Date:

Relationship (if patient a minor): Witness (signature):